Statement of the
American College of Radiology
To the
House Ways and Means Health Subcommittee's
Hearing on MedPAC's Annual March Report to Congress

Tuesday, March 15, 2011

The American College of Radiology (ACR), a professional organization representing more than 34,000 radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians, and medical physicists, is pleased to submit testimony for the record regarding the Ways and Means Health Subcommittee's "Hearing on the Medicare Payment Advisory Commission's (MedPAC) Annual March Report to Congress." Although the hearing was primarily focused on MedPAC's March 2011 Report, ACR is taking this opportunity to comment on a specific issue raised at the Commission's February 23, 2010 session: "Improving Payment Accuracy and Appropriate use of Ancillary Services". ACR's specific concern lies with a particular MedPAC-suggested resolution to the problem of physician self-referral that may become part of its June 2011 report.

The ACR initially applauded the June 2010 MedPAC report which noted that any recommendations to control growth in imaging should include critical review of the current services exempted under the in-office ancillary exception (IOASE) with recommendations to severely limit and/or regulate the practice of self-referral. In the months leading up to the February 2011 MedPAC meeting, the ACR had been encouraged by the amount of time and analysis devoted to this issue by MedPAC staff and the Commission and fully anticipated a workable solution would be offered. Unfortunately, MedPAC offered draft recommendations that are nothing more than a continued commentary on the misperception that imaging services are overpriced and that somehow this drives self-referral. The College views MedPAC's continued misperception as ignoring the role that physician ownership plays in skewing clinical decision making and increasing utilization of imaging services.

Specifically, ACR is concerned with MedPAC's proposal to curb the practice of self-referral through an imaging reimbursement policy that would apply a multiple procedure payment reduction (MPPR) to the professional component (PC) of multiple imaging procedures performed on a single patient in one day. MedPAC appears to have lifted this policy from a 2009 Government Accountability Office (GAO) report that proposed expanding the MPPR to the PC. The 2009 GAO report mischaracterized potential MPPR savings based on duplication of pre-service and post-service work. GAO also equated less intense pre-service and post-service work with intra-service work, which dramatically overstates the potential savings. This flaw in GAO's

understanding of the valuation of physician work in the Medicare Physician Fee Schedule (MPFS) made ACR question the validity of the entire GAO report. The ACR vehemently disagreed with GAO's proposal to apply the MPPR to the PC and expressed this sentiment formally as part of an American Medical Association (AMA) response to this report.

Now MedPAC, apparently without verifying the original GAO data and without gathering any further data of its own, has resurrected this ill-conceived proposal (**MedPAC Draft Recommendation 2: Congress should direct the Secretary to apply Multiple Procedure Payment Reductions (MPPR) to the physician work component (of the Physician Fee Schedule) in addition to the technical component)**. As in 2009, ACR still maintains that while there may be some efficiencies gained under the technical component portion (TC) of the fee schedule for performing contiguous body part imaging services, it is not entirely clear how MedPAC or GAO envisions gaining similar efficiencies from the PC portion.

The Subcommittee, as well as the rest of Congress, must understand the PC for imaging services primarily represents the interpreting physician's time and effort (i.e., physician work). In the case of multiple imaging studies during the same session, whether they involve contiguous or non-contiguous body areas, the same modality or different modalities, or a single session or multiple sessions during the same day, the number of images required to be interpreted is additive, with few, if any, measureable economies of scale. Each imaging study produces its own unique set of images that must be interpreted in their entirety, separately dictated and written in separate reports to the referring physician. Thus, the interpreting physician must expend the same amount of time and effort (work) to interpret each individual imaging study. Therefore, based on the current dynamic as it pertains to the interpretation of imaging services, and that neither the GAO nor MedPAC seems to be able to justify their proposal, the ACR believes there is no reasonable or rational reason that CMS or Congress should apply the MPPR to the physician work component (PC) for multiple imaging services.

In conclusion, the specialty of radiology, and specifically payments for the advanced imaging modalities, has been the focus of payment reductions both legislatively and through the regulatory process for several years now. These payment reductions are making it increasingly difficult, even impossible, for many radiologists to keep their offices and freestanding imaging centers open while actual practice costs continue to increase, therefore reducing patients' access to timely, non-emergent imaging services. Additional cuts, such as the MedPAC-suggested MPPR for the PC of imaging services, are not only unjustified and reflect a total lack of understanding of the medical image interpretive process, but also would continue to severely erode the ability of radiologists to offer their patients the choice to seek a non-hospital setting for their imaging services.

As always, the American College of Radiology appreciates the opportunity to share its views on this matter and is committed to working with the Health Subcommittee members and staff to maintain timely access by Medicare beneficiaries to these services.

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